(17) (18) (18)

Nos. 93-1408, 93-1414, 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD *Petitioners,*

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*, *Respondents.*

MARIO M. CUOMO, *et al.*, *Petitioners,*

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*, *Respondents.*

HOSPITAL ASSOCIATION OF NEW YORK STATE, *Petitioners,*

v.

THE TRAVELERS INSURANCE COMPANY, *et al.*, *Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF AMICUS CURIAE OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENTS

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Dated: December 13, 1994

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

34 pp

TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

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INTRODUCTION

The National Coordinating Committee for Multiemployer Plans ("NCCMP") urges this Court to affirm the decision of the Court of Appeals for the Second Circuit and to rule that diagnosis related group ("DRG") surcharges are preempted by ERISA, in particular, as applied to self-funded multiemployer plans. All parties to this proceeding have consented to the NCCMP's request to file a brief *amicus curiae* in support of Respondents, and letters confirming their consent have been provided to the Clerk of the Court.

Petitioners in effect urge this court to create a judicial exemption from ERISA preemption for state health care financing statutes on the grounds that these laws fall within traditional state police powers and serve an important social goal. In advocating this position, Petitioners disregard the fact that ERISA plans, in particular, self-funded multiemployer plans also serve an important social function,[1] have limited resources, and are subject to specific federal restraints. More importantly, Petitioners and their *amici* minimize the legal significance of the fact that New York's hospital rate-setting law, because of its selectively-imposed surcharges, disproportionately burdens such plans, and thereby either threatens the ability of these plans to continue to provide benefits or directly influences the choices by which benefits can be provided—results that are not only inimical to the general objectives of ERISA and the specific goal of ERISA preemption but could actually lead to an increase in the population of uninsured citizens.

The Second Circuit, holding that the surcharges imposed by the New York law are preempted as applied to ERISA plans, issued a ruling that is clearly consistent with the plain language of ERISA's preemption provision as well as with every decision of this Court which has

[1] *See Lewis v. Benedict*, 361 U.S. 459, 468-470 (1960).

interpreted the scope of ERISA preemption. Petitioners, however, recommend a "cost of doing business" standard to determine whether a state law of purported general applicability—despite its selective and inordinate impact on ERISA plans—should nevertheless be given full regulatory effect on the grounds that economic burdens, however onerous, are too tenuous, remote, and peripheral to trigger ERISA preemption. More importantly, Petitioners and their *amici* argue that a state law's economic impact alone, even if substantial, does not constitute a sufficient "connection" to ERISA plans to cause the law to "relate to" the plan within the meaning of Section 514(a) of ERISA.[2]

As the NCCMP will show, this approach ignores the economic reality in which self-funded multiemployer plans operate. Moreover, the NCCMP is concerned that if the Petitioners' standard is adopted in connection with New York's hospital rate-setting statute, there will be no principled basis upon which to draw the line in favor of preemption in other cases, unless the particular state law expressly refers to employee benefit plans or contains a direct mandate. Since most state laws of purported general applicability do not expressly reference ERISA plans, or could be drafted to avoid such express reference, the NCCMP is concerned that if a law's economic impact is entirely excluded from the preemption analysis, self-funded plans (whose resources are limited) will be increasingly compelled to contribute towards the costs of other state health programs or to other social programs not related to health on the grounds that the state-mandated diversion of fund assets is a "mere" cost of doing business in the state[3]

[2] Section 514(a) of ERISA, 29 U.S.C. 1144(a), provides that "the provisions of this Title and Title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."

[3] Arguments raised in the *amicus* brief of the States of Minnesota *et al.* confirm that this specific concern is justified. *See* Brief, p. 26.

Such a result would not only erode the financial soundness of multiemployer plans, but would undermine the goals Congress sought to promote through ERISA's preemption provision; namely, to insulate employee benefit plans from all state regulations that affect the administration, structure, or solvency of such plans, except for those matters which Congress—in the exercise of its legislative powers—expressly exempted.

INTEREST OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The NCCMP is a nonprofit, tax-exempt organization that was formed after the enactment of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001-1461 ("ERISA"), to participate in the further development of employee benefits legislation, government regulations promulgated to implement ERISA, and other laws affecting multiemployer plans. Currently, more than 240 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans are representative of all of the nation's multiemployer plans, which cover more than nine million workers.

As noted above, New York has enacted a hospital rate-setting statute which imposes DRG surcharges, payable by multiemployer plans, that have no relation to the services provided or the benefits received by the plan's participants and beneficiaries. Although the surcharges were purportedly designed to implement social goals deemed important to the state, the Second Circuit held that the surcharges were preempted as applied to ERISA plans. The NCCMP has a strong interest in seeking affirmance of the Second Circuit's opinion, as DRG surcharges have already adversely affected NCCMP affiliates, which represent a majority of participants in self-funded multiemployer plans.

Because of the broad range of the NCCMP's constituent organizations and its contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary principles, the NCCMP believes that it is qualified to advise the Court of the practical implications of the decision below for self-funded multiemployer plans and to state the position of the trustees, participants, and beneficiaries of such plans.[4]

The NCCMP endorses the reasoning of the District Court for the Southern District of New York[5] and the Court of Appeals for the Second Circuit,[6] and therefore supports Respondents in seeking affirmance of the court of appeals' decision. Respondents have correctly demonstrated why New York's law should be preempted because of its direct influence on a plan's choice of insurer. In this brief, the NCCMP will focus primarily on the adverse impact which cost-shifting laws like New York's will have on the ability of self-funded multiemployer plans to provide high-quality, cost-effective health care through mechanisms of their own choosing.

SUMMARY OF ARGUMENTS

In seeking affirmance of the Second Circuit's decision, the NCCMP supports Respondents in urging this Court to rule that New York's DRG surcharges, which differentially and disproportionately burden all ERISA plans and impermissibly influence their choices for providing benefits, are preempted by ERISA. Nevertheless, to the

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[4] The NCCMP has participated as an *amicus curiae* in numerous cases involving important issues affecting multiemployer plans. *See, e.g., Local 144 Nursing Home Pension Fund, et al. v. Demisay*, 113 S. Ct. 2252 (1993); *Concrete Pipe & Products of California v. Construction Laborers Pension Fund for Southern California*, 113 S. Ct. 2264 (1993); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

[5] *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

[6] *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993).

extent distinctions exist, the NCCMP believes that it is urgent for the Court to consider at this time the impact of the surcharges and similar cost-shifting mechanisms on self-funded ERISA plans, in particular, multiemployer plans, and to clarify that the surcharges are preempted as applied to those plans.

The NCCMP rejects Petitioners' "cost of doing business" standard. In the NCCMP's view, DRG surcharges should be declared preempted—even without regard to their specific economic impact—because this type of cost-shifting, by definition, directly "relates to" ERISA plans. Alternatively, if the cost-shifting effect of New York's surcharges is characterized as the indirect result of a state law of general applicability, Congress's concern with the financial soundness of ERISA plans compels this Court to weigh the economic impact of the surcharges. In addition, even in the absence of cost-shifting, there is nothing in ERISA, its legislative history, or this Court's precedents to support the view that the economic impact of a state law, even one of purported general applicability, should be excluded from the preemption analysis merely because the economic impact of the law is alleged to be indirect or because its effects—whether direct or indirect—are solely economic.

The impact of New York's law imposing DRG surcharges is neither indirect nor purely economic. Moreover, cost-shifting statutes like New York's are not only economically threatening to multiemployer plans; they are also inconsistent with fundamental principles of ERISA and affect trustees' fiduciary obligations with respect to maintaining a sound funding policy and deploying fund assets in the sole and exclusive interest of plan participants and beneficiaries.

Mischaracterizing DRG surcharges as a cost of doing business in the state, Petitioners are in effect requesting this Court to create a judicial exemption for state health care financing laws. However, such an exemption would impermissibly intrude upon an area reserved exclusively

to Congress. The language of ERISA Section 514 does not tolerate judicial exemptions for state laws relating to ERISA plans, even if those laws serve useful social purposes. Rather, § 514(a) supersedes *all* state laws relating to employee benefit plans other than those which Congress expressly exempted.

Congress knew how to draft an express exemption for state health care financing statutes and did so for Hawaii's Prepaid Health Care Act, 29 U.S.C. § 1144(b)(5)(A). More recently, legislative efforts have been made—to date unsuccessfully—to enact additional exemptions for other state health care financing laws, including DRG statutes similar to New York's. Pending national health care reform, or Congressional action with respect to state health care financing laws, this Court should reject the "cost of doing business" standard, adopt a preemption standard that will require courts to invalidate state laws imposing selective and differential burdens on ERISA plans, such as DRG surcharges, and clarify that economic considerations may justify preemption even if a state law is facially neutral.

ARGUMENTS

I. NEW YORK'S DRG SURCHARGES, BY DEFINITION, "RELATE TO" ERISA PLANS; MOREOVER, THE SECOND CIRCUIT'S PREEMPTION ANALYSIS CORRECTLY TAKES INTO ACCOUNT THE ECONOMIC BURDEN OF THOSE SURCHARGES.

A. This Court should clarify that New York's law imposing DRG surcharges is preempted as applied to self-funded multiemployer plans.

As a threshold matter, the NCCMP urges this Court to consider (separately, if necessary) the impact of New York's law imposing DRG surcharges on self-funded multiemployer plans and to decide that this law is preempted as applied to these plans.

Petitioners and other *amici* (including the United States) concede that the New York law at issue in this case encompasses self-funded ERISA plans and imposes a 13 percent surcharge on those plans. It is likewise acknowledged that self-funded ERISA plans may choose to provide benefits through HMOs, in which case the 9 percent surcharge assessed on HMOs that do not meet the state's goals for enrolling Medicaid patients will increase the costs of providing health benefits because the 9 percent assessment will be passed on to the plans in the form of higher rates.[7]

In view of the New York law's inclusion of self-funded ERISA plans, the United States in its *amicus* brief concedes that "application of the 13 percent surcharge to 'self-insured funds' may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves." *See* Brief, p. 12, n.5. Stressing that its brief is addressed only to insured plans, however, the United States urges this court

[7] *See* Brief of Respondent New York State Health Maintenance Organization Conference *et al.*, in opposition to Petition for Certiorari, p. 18.

not to decide the question of whether the surcharges are preempted as applied to self-insured plans. Rather, the United States requests this Court to remand that issue to the court of appeals and (if necessary) to the district court to determine whether that issue has been properly presented in the case and, if so, how it should be resolved in light of the Court's ultimate decision. Petitioners themselves have not made such a request, and the NCCMP strongly objects to this suggestion of the United States for the following reasons.[8]

First, the United States has conceded that some of the complaints filed in this case include one or more self-insured plans and the fiduciaries of such plans. *See* Brief, p. 12, n.5. Therefore, self-funded plans and their trustees were before the courts below. Moreover, as Respondents' briefs opposing the Petition reveal, the courts below were fully aware of the fact that self-insured plans were within the reach of New York's rate-setting law and subject to the impact of that law. Because the courts below found that the surcharges "related to" all ERISA plans and were not laws regulating insurance within the meaning of the savings clause, the courts did not need to treat self-funded plans separately from insured plans, either for purposes of the preemption provision, the savings clause, or the deemer clause.[9] Since the courts below clearly included

[8] Noting that over half of all United States workers are covered by self-insured plans, the States of Minnesota *et al.*, as *amici* for Petitioners, also urge the Court to resolve this issue. *See* Brief, p. 22, n.11.

[9] The "savings" clause, Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), provides that "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities." The "deemer" clause, Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), provides in pertinent part—that "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts . . . ."

the subset of self-funded ERISA plans within the ambit of their rulings, it is appropriate and necessary for this Court to include self-funded plans in its present considerations (even if distinctions do prove necessary) as nothing would be gained from further litigation below in light of well-established applicable precedent. Moreover, self-funded multiemployer plans will be exposed to irreparable harm through delay, *infra*.

Second, Petitioners requested *certiorari*, in part, to resolve a conflict between the Second Circuit's *Travelers* decision and the Third Circuit's *United Wire* decision.[10] In *United Wire* (and the multiple related cases objecting to New Jersey's DRG surcharges), plaintiffs were almost exclusively self-funded multiemployer plans and their trustees. Accordingly, a preemption standard applicable to self-funded plans is particularly important at this time, as both *Travelers* and *United Wire* have generated further conflicting decisions involving self-funded plans. *See NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) and *New England Health Care Emp. Union Dist. 1199, SEIU AFL-CIO v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn. 1994) (following Second Circuit); *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994), *appeal docketed*, No. 94-2237 (8th Cir. May 18, 1994) (following Third Circuit).

Third, Petitioners request this Court to rule that even if New York's DRG surcharges "relate to" ERISA plans, they should be "saved" from preemption under Section 514(b)(2)(A) of ERISA as a law regulating insurance. Since this Court has firmly established a bright-line legal distinction between insured and self-funded plans for purposes of applying the "savings" clause, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *FMC*

[10] *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir. 1993), *cert. denied*, 114 S. Ct. 382 (1993).

Corp. v. Holliday, 498 U.S. 52 (1990),[11] it is appropriate and necessary for the Court to consider the application of the surcharges to self-funded plans in the event it finds that the surcharges "relate to" all ERISA plans but are "saved" from preemption as state insurance laws. It may be noted that the district court has already ruled, and the court of appeals has at least implicitly affirmed that the "13% surcharge referring to self-insured plans could not possibly fall within the savings clause because . . . self-insured plans do not engage in the 'business of insurance' as a matter of law." (Pet. App. A-79.)

Finally, an incomplete decision with regard to the scope of preemption would be extremely detrimental to self-funded multiemployer plans, which have already been adversely affected by the *United Wire* decision and can anticipate further adverse consequences in the event New York's DRG surcharges are upheld without a consideration of their impact on self-funded plans. This is particularly true since other states may be encouraged to enact cost-shifting statutes similar to that of New York, pending national health care reform, *infra*.

In *United Wire*, Judge Nygaard, in a strong dissenting opinion favoring preemption, explained how the New Jersey DRG surcharges would impose a staggering economic burden on ERISA plans:

> The surcharges are paid not by the general public at large, but by the less than 25 percent of the popula-

[11] As noted above, *supra* n. 9, self-funded ERISA plans are "deemed" not to be insurers or engaged in the business of insurance with respect to state laws "saved" from preemption as laws regulating insurance. Accordingly, in *Metropolitan Life*, this Court exempted self-funded plans from the reach of state-mandated benefit laws while holding that such benefits had to be included in commercial insurance policies even though such policies are marketed to ERISA plans. Similarly, in *FMC Corp. v. Holliday*, the Court exempted self-funded plans from the reach of state anti-subrogation laws, although insured plans will continue to be subject to the antisubrogation provisions of state automobile insurance laws.

> tion who use hospital services. Of those 25 percent, about 75 percent receive the uncompensated care assessments challenged here. ERISA plan participants comprise only about 15 percent of the hospital patients, but pay about 40 percent of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.

995 F.2d at 1199. Indeed, one NCCMP affiliate, the Hotel Employees and Restaurant Employees International Union Welfare Fund, advised that in 1992 and the first months of 1993, it had placed $1,172,096.14 into escrow pending the outcome of the litigation. (A further $533,503.25 was paid under protest.)

Although the courts below did not quantify the precise economic impact of the New York surcharges, they clearly believed that a 13 percent surcharge on a DRG rate whose components already included factors other than the actual cost of providing the covered benefit resulted, in the aggregate, in a sufficiently substantial burden to trigger preemption. While Petitioners and their *amici* dispute the impact, and regard even a substantial economic burden as part of the cost of doing business in the state, they do not seriously deny that the New York surcharges impose significantly higher costs on ERISA plans that could alter plan design.

Given the obvious economic impact of New York's DRG surcharges on self-funded multiemployer plans, the absence of certainty with regard to preemption is clearly harmful, as limited fund assets continue to be diverted into the coffers of hospitals, the state, or into escrow accounts and away from their primary purpose of paying benefits to eligible workers and their families.

Moreover, the need for certainty has become particularly acute as a result of the Omnibus Budget Reconciliation Act of 1993 ("OBRA '93"), P.L. No. 103-66, 107 Stat. 312, § 13442, 26 U.S.C. § 162(n). As Respondents have noted in their briefs opposing the Petitions filed in

this case, Congress amended Section 162(n) of the Internal Revenue Code relating to business deductions, apparently in anticipation of the district court's *Travelers* decision but before the court of appeals issued its ruling confirming that the surcharges are preempted. In effect, the amendment provides that employers will lose their tax deduction for any amounts paid or incurred in connection with a group health plan (including a self-funded plan) if the plan does not pay the 13 and 9 percent surcharges for services provided by New York hospitals between February 2, 1993, and May 12, 1995.

The Conference Committee Report specifically states that "[n]o inference is intended as to whether any provision of the New York all-payer hospital reimbursement system is preempted by ERISA." H.R. Conf. Rep. No. 213, 103rd Cong. 1st Sess. 734 (1993), *reprinted* in 1993 U.S.C.C.A.N. 1088, 1423. Therefore, it is arguable that the loss of the tax deduction was not intended to apply in the event the New York law is declared invalid. Nevertheless, Respondents indicate (and the NCCMP concurs) that few multiemployer plans were willing to risk the consequences of nonpayment even after the court of appeals ruled that the surcharges were preempted and unenforceable, although some plans advised hospitals that they were escrowing amounts equivalent to the surcharges pending an ultimate determination by this Court.[12]

This situation, however, places the trustees of multiemployer plans in an anomalous and untenable position. On the one hand, they need to assure contributing employers that the plan will comply with the surcharge requirement so that the employers will not bargain out of the plan in response to the potential loss of a significant

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[12] Although Section 162(n) is scheduled to expire in May 1995, this issue is not moot for several reasons. First, the provision may very well be extended; second, considerable amounts of money are in escrow; third, at least some plans have refused to pay the surcharges.

tax deduction.[13] On the other hand, the payment of surcharges under a law which the court of appeals has declared is preempted raises substantial fiduciary implications. For example, such payments arguably violate Section 403(c)(1) of ERISA, 29 U.S.C. § 1103(c)(1), because they ultimately "inure to the benefit" of employers by preserving their tax deduction for contributions. Moreover, since payment of the surcharges is unrelated to benefits received by participants, and ultimately inures to the benefit of nonparticipants, payment of the surcharges arguably also violates Section 404(a) of ERISA, 29 U.S.C. § 1104(a), which imposes on trustees a fiduciary duty to expend fund assets solely and exclusively to pay benefits to participants and beneficiaries except to defray the reasonable costs of trust administration.

While a favorable ruling by this Court would not serve to repeal Internal Revenue Code Section 162(n), employers contributing to multiemployer plans would be better able to challenge the loss of a tax deduction in the event a plan refuses to release the money from its escrow account or otherwise fails to comply with the law. Indeed, it is unlikely that the Treasury Department would seek to enforce the amendment in that circumstance. More importantly, such a ruling would undoubtedly shift the focus of attention from the courts to Congress, where a more permanent resolution of the preemption issue properly belongs. As will be discussed below, New York and other states have expressly requested Congress to waive preemption for their health care financing laws. The NCCMP submits that this is the correct way for states to obtain permission to "experiment" with these matters.

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[13] Adverse tax consequences and/or increased contribution rates necessitated by cost-shifting laws clearly offer employers incentives to bargain out. Since ERISA's withdrawal liability provisions (29 U.S.C. §§ 1381-1461) apply only to withdrawals from multiemployer pension plans, and there are no corresponding provisions for health plans, employer withdrawals from multiemployer health plans could ultimately result in the demise of these plans.

In sum, the NCCMP respectfully requests that this Court address and resolve the issue whether New York's DRG surcharges are preempted as applied to self-funded multiemployer plans, as further delay will expose these plans to irreparable harm. As we shall now show, existing precedent requires a ruling that ERISA preempts the DRG surcharges as applied to these plans.

B. Petitioners' "cost of doing business" standard is inimical to the financial health of multiemployer plans.

It is now well established that ERISA was enacted to promote the financial stability of employee benefit plans and to assure that American workers receive the benefits upon which they rely. *Nachman Corp. v. PBGC*, 446 U.S. 359 (1980).

It is equally well established that the costs of providing health care have escalated out of all proportion,[14] and are threatening either to destroy private welfare plans or to force those plans to take drastic measures to remain solvent, including restricting or eliminating a whole range of benefits and terminating coverage for retirees.

In response to the health care problem, both New York and New Jersey enacted hospital rate-setting laws designed to contain the costs of health care within the state and to assure the financial solvency of their hospitals. As Respondents emphasize, New York's law differs from the New Jersey law at issue in *United Wire*, because it seeks to directly influence ERISA plans in the selection

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[14] *See Clinton Administration Description of President's Health Care Reform Plan, American Health Security Act of 1993, dated September 7, 1993*, BNA Special Supplement (September 13, 1993). According to this Report, health care costs are rising faster than other sectors of the economy; will consume about two-thirds of the increase in the Gross Domestic Product ("GDP") for each American for the rest of the decade; and will grow from 14 percent of the GDP to 19 percent without regard to an expansion of coverage to insure all Americans. (S-3.)

of an insurer, *i.e.*, to encourage them to shift from commercial insurers to the Blues. Nevertheless, both statutes share a common feature, in that they are predicated on *base* DRG rates (applicable to hundreds of specific types of treatment) designed to offer hospitals incentive to control costs while compensating them for the direct and indirect costs of providing services. Moreover, both laws contain DRG *surcharges* that are unrelated to the costs of the benefits received by plan participants. The NCCMP challenges only the surcharges [15] as imposing a selective and impermissible burden on self-funded multi-employer plans that directly affects their structure and administration, if not their very existence.

While New York's base DRG rates include a component for bad debts and charity care,[16] the law additionally requires ERISA plans (including self-funded plans) to pay hospitals a 13 percent surcharge or 113 percent of the base DRG rates. Similarly, HMOs are subject to a maximum 9 percent surcharge, depending on how many Medicaid recipients they enroll. However, no surcharge is added to the base DRG rates for patients covered by Medicaid or by a Blue Cross/Blue Shield plan (the "Blues"). As conceded by all Petitioners and their *amici*, a primary purpose of the 13 percent surcharge is to encourage participation in the Blues by making those

[15] Under the New Jersey law, self-funded ERISA plans were compelled to pay surcharges of up to 37 percent of the base DRG rate, *e.g.*, a 19.1 surcharge to reimburse the hospital for the costs of providing uncompensated care (including bad debts); a 7 percent surcharge to reimburse the hospital for the difference between federal Medicare payments for specific services provided and the DRG rates established for those services (payable by non-Medicare recipients); and a maximum 11 percent surcharge to reimburse the hospital for discounts permitted to certain high volume insurers such as Blue Cross and Blue Shield and to plans having open enrollment. This funding mechanism was amended, effective January 1, 1993, to eliminate the DRG system of rate setting in favor of deregulated market competition.

[16] N.Y. Pub. Health Law, § 2807-c *et seq.* (McKinney 1993).

plans more competitive with commercial insurers, while the purpose of the 9 percent assessment is to encourage HMOs to enroll more Medicaid recipients to lower the costs of the Medicaid program. It is not seriously disputed that the 9 percent surcharge assessed on HMOs will ultimately be passed on to plans in the form of higher rates, which may influence a decision with regard to their continued use.

Given the above, it is clear that this Court may affirm the Second Circuit's opinion without addressing the Third Circuit's decision in *United Wire*, as the facts clearly demonstrate the relation of the New York law to ERISA plans, *infra*. However, if the Court reaches *United Wire*, the NCCMP urges that the decision be rejected for the following reasons.

This Court has repeatedly emphasized that "ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a Section 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect." *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580 (1992) (citations omitted). The issue in this case is therefore whether a state hospital rate-setting law which disproportionately burdens ERISA plans through selectively-imposed surcharges has sufficient "connection with" such plans to trigger ERISA's preemption clause.

The courts below correctly found that New York's DRG surcharges "relate to" ERISA plans within the meaning of this Court's precedents because they not only substantially increase the cost of providing benefits but could actually lead to changes in the way a plan provides benefits or to a reduction or elimination of benefits. Accordingly, the surcharges were held to be preempted by ERISA.

In *United Wire*, the Third Circuit found that the DRG surcharges imposed on ERISA plans were not preempted.

The court reasoned that despite the surcharges, the rate-setting statute was "a generally applicable law" that was not intended to regulate the affairs of ERISA plans; did not single out such plans for special treatment; was not predicated on the existence of ERISA plans; had no effect on the structure or administration of such plans; and—in sum—did not "relate to" ERISA plans.

Although the Third Circuit acknowledged that the surcharges would impose an economic burden on ERISA plans, the court found that "[t]his effect is no different in kind . . . from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, *i.e.*, utility costs, the wages of its employees, waste disposal costs, etc." 995 F.2d at 1193.

Moreover, although New Jersey conceded that its hospital rate-setting law would not be "viable" without ERISA plans, the Third Circuit also concluded that this economic fact did not trigger preemption although the state's concession was tantamount to an admission that the DRG law was designed to selectively and disproportionately burden ERISA plans and would have no meaningful existence without them.[17]

Following the reasoning in *United Wire*, Petitioners and their *amici* urge that ERISA's preemption provision was not intended to insulate employee benefit plans from regulated markets. They therefore argue that unless state health care financing laws (and by analogy other regulatory laws enacted by states under their police powers) directly refer to ERISA plans or indirectly dictate or restrict plan content or administration, the law's economic impact (even if substantial) should be excluded in determining whether the law is preempted.[18]

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[17] *Compare* 995 F.2d at 1192, n.6 *with* dissent at 1199-1200.

[18] *See*, for example, Petitioner Cuomo's Brief, pp. 10-11. In this regard, however, the *amicus* brief of the States of Minnesota *et al.*, suggests a narrower standard; namely, that state laws having an indirect but substantial impact on ERISA plans should be preempted only if they treat ERISA plans differentially. *See* Brief, pp. 27-28.

In support of this position, Petitioner Cuomo, on behalf of the State of New York, argues that "health care assessments, like state regulation of hospital capital improvements, medical waste disposal, minimum hospital staffing requirements, and a whole host of other regulations, increase the cost of providing medical care and, therefore, the cost of health care coverage provided by the plans. As the cost of medical care increases, plans may respond by reducing benefits, but there is nothing in ERISA's language, structure, or legislative history to indicate that ERISA was designed to protect participants from this possibility." *See* Cuomo Brief, p. 11, and similar arguments raised in the other briefs seeking reversal of *Travelers*.

Petitioners and their *amici*, however, overstate the case by confusing the cost of doing business with cost-shifting. As noted earlier, New York's *base* DRG rates (like those of New Jersey) already factored in the operational costs of providing hospital services; indeed, New York's base DRGs include a nondiscriminatory factor related to the cost of providing care for the indigent and uninsured. Clearly, *base* DRG rates applicable to all payers can be arguably justified as part of the cost of doing business in the state. However, DRG *surcharges* which are selectively imposed for reasons unrelated to the cost of the services being provided and which disproportionately burden ERISA plans reflect a cost-shifting mechanism which is qualitatively different from a neutral cost of doing business, such as the cost of waste management. In the NCCMP's view, the DRG surcharges should be preempted —even without regard to their specific economic consequences—because this type of cost-shifting, by definition, directly and blatantly "relates to" ERISA plans.

On the other hand, if the cost-shifting effect of New York's DRG surcharges is characterized as an indirect result of a state law of general applicability, Congress's concern with the financial soundness of ERISA plans compels this Court to weigh the economic impact of the surcharges.

Finally, even in the absence of cost-shifting, there is nothing in ERISA, its legislative history, or in this Court's precedents to support the conclusion that the economic impact of a state law, even one of purported general applicability, should be excluded from the preemption analysis merely because the economic impact of the law is alleged to be indirect or because the effects of the law—whether direct or indirect—are solely economic.

With regard specifically to self-funded ERISA plans, the NCCMP disagrees with Petitioners' general proposition that the impact of New York's law is indirect and purely economic. Clearly, the 13 percent surcharge is direct because self-funded plans must pay the surcharge that is added to the hospital bill of each and every participant and beneficiary. If the plan has a significant number of participants in New York, the aggregate cost of the surcharges would likely be substantial. As the courts below clearly recognized, these costs could lead to a reduction or elimination of benefits.

Moreover, the economic impact of both the 13 and 9 percent surcharges could require a change in plan design beyond the reduction or elimination of benefits. As Respondents emphasize, the plan could be compelled to abandon its existing mechanisms for providing health benefits and, solely for reasons of cost, convert to the Blues (a stated goal of the New York law!).[19] To the extent

[19] While many ERISA plans voluntarily choose to provide coverage through Blue Cross and Blue Shield, trustees of self-funded ERISA plans might have serious concerns if compelled to convert to the Blues, particularly in New York. This Court may take judicial notice that the Blue Cross/Blue Shield—Empire Plan (New York) has recently been the subject of an intensive investigation by the Senate Committee on Governmental Affairs. *See Oversight of the Insurance Industry: Blue Cross/Blue Shield—Empire Plan (New York): Hearings Before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs United States Senate*, 103rd Cong., 1st Sess. (1993).

the plan ceases to provide benefits through an HMO, participants would suffer a disruption in their medical treatment, as HMOs provide medical services and are not merely payers. In addition, since the Blues might not provide a level of benefits satisfactory to participants, or process claims in the manner desired, such a change in plan design could adversely affect subsequent collective bargaining negotiations. To the extent employers bargain out, a multiemployer plan's asset pool, which is generated by employer contributions, would be diminished. Depending on the size of the plan, its very existence could be jeopardized.

C. This Court's preemption analysis should take into account the realities in which self-funded multiemployer plans operate.

The NCCMP believes that selectively-imposed surcharges, and similar cost-shifting statutes, directly affect all ERISA plans and therefore "relate to" these plans in a manner that triggers preemption under ERISA Section 514(a). Moreover, the NCCMP believes that even if a state law has an indirect and/or solely economic impact on an ERISA plan, the economic effect of the law should be included in the preemption analysis.[20]

[20] The NCCMP also agrees with the courts below, and with Respondents, that the DRG surcharges should not be "saved" as a law regulating insurance. However, in the event this Court finds that the surcharges "relate to" ERISA plans under § 514(a) but are "saved" under § 514(b)(2)(A), the NCCMP requests that the Court clarify that self-funded multiemployer plans are protected from the surcharges by § 514(b)(2)(B), as these plans are not subject to state insurance regulation.

Because of the realities in which self-funded multiemployer plans operate, cost-shifting strategies are particularly harmful to these plans. Therefore, these realities should be taken into account in evaluating the merits of the Second Circuit's approach to preemption.

Multiemployer employee welfare benefit plans are created by the parties to collective bargaining agreements for the purpose of providing health and welfare benefits to workers and their families. In addition, many welfare benefit plans provide sorely needed coverage to retirees.

Most collectively bargained plans are self-funded through the ongoing contributions of several, hundreds, or even thousands of employers in one or more industries involving participants working or living in one, several, or many states. The contributions are pooled for investment to provide benefits to all participants in the plan, and their families. A key feature of multiemployer plans is that participants can move from one contributing employer to another within the plan without losing their benefit rights, making such plans a model for portability. In addition, multiemployer plans—rather than employers—provide COBRA benefits if a worker is terminated or laid off or some other qualifying event occurs even if the employee's employer subsequently bargains out of the plan.[21]

Although self-funded multiemployer plans provide a socially desirable function and have enormous obligations, amounts available to pay benefits are limited by the fact that employer contributions are only one component of an employer's labor costs and, in general, have not been uniformly able to keep pace with spiraling health care costs. As Robert A. Georgine, Chairman of the NCCMP, explained in a letter to the Speaker of the House:

[21] *See* Sections 601-607 of ERISA, 29 U.S.C. §§ 1161-1167; 26 U.S.C. § 4980 B; and *South Central United Food and Commercial Workers Unions and Employers Health and Welfare Trust v. Appletree Markets*, 19 F.3d 969 (5th Cir. 1994).

> Collectively-bargained employer contributions to multi-employer health plans are part of a covered worker's compensation package for his or her labors. Such contributions are in lieu of cash wages. Workers forego a portion of their wages and wage increases to have their employers contribute to multi-employer health plans. Increases in plan costs caused by taxes and other government-imposed charges divert plan assets away from benefits for the covered workers and their families. Increased plan costs mean increases in the rate of contributions, and declining wages, as a greater portion of the worker's compensation package is allocated to health plan contributions instead of wages.
>
> Our plans are already troubled by the uncontrolled inflation in health care costs and cost-shifting, and covered workers are increasingly faced with benefit cutbacks and wage reductions as a result. The economic recession has exacerbated these troubles, as the lack of work causes declines in plan contribution income and increases in benefit usage.[22]

Far from being a deep pocket, self-funded multiemployer plans have become increasingly threatened, not only by the factors stated above, but by labor unrest precipitated by the rising costs of health care and therefore demands for increased contributions. For example, a three-year study prepared a few years ago by the Service Employees' International Union concluded that the number of strikes over who will pay the rising costs of health care have increased by more than 300 percent since 1986, and that such work stoppages in 1989 alone cost the United States economy more than $1.1 billion in lost wages and productivity.[23] Absent health care reform, there is no

[22] Letter from Robert A. Georgine to the Honorable Thomas S. Foley, Speaker of the House of Representatives, dated May 21, 1993, urging a national solution to the health care crisis.

[23] *See Labor & Management: On a Collision Course Over Health Care*, 17 Pen. Rep. (BNA) 375 (Feb. 26, 1990).

reason to believe that health benefits will become less important as a mandatory subject of bargaining and therefore as a potential source of labor disputes. Given the relatively fragile nature of multiemployer plans and the environment in which they operate, the "cost of goods and services" analysis of the Third Circuit is particularly inapposite.

Cost-shifting statutes are not only economically threatening to multiemployer plans; they are also inconsistent with fundamental principles of ERISA.

First, trustees have a fiduciary obligation to maintain a sound funding policy. Therefore, although the parties to collective bargaining agreements negotiate the amount of money the employer agrees to dedicate to providing health benefits, it is the trustees of self-funded multiemployer plans who normally have sole discretion and authority—under the governing trust agreement and applicable benefit plan—to determine the type and range of benefits the plan can and will provide and to establish eligibility requirements on the basis of the plan's financial resources and such actuarial considerations as the number and age of participants and previous claims experience. These are sensitive determinations that frequently require the input of the fund's actuarial consultant. *Ad hoc* and selectively-imposed surcharges clearly interfere with the trustees' funding responsibilities and upset the actuarial determinations upon which their decisions are made.

Second, the premise of eligibility for benefits in a self-funded multiemployer plan is coverage under a written collective bargaining agreement.[24] Since Section 404(a) of ERISA, 29 U.S.C. § 1104(a), imposes on trustees the

[24] Section 302(c)(5) of the Labor Management Relations Act of 1947 ("LMRA"), as amended, 29 U.S.C. § 186(c)(5), prohibits employers from making and employee benefit plans from accepting contributions except pursuant to a detailed written agreement specifying, among other things, the persons on whose behalf the contributions are being made.

fiduciary obligation to act in the sole and exclusive interest of the plan's participants and beneficiaries, fund assets may not be used to pay benefits to individuals other than to employees covered by collective bargaining agreements and their families, except as otherwise permitted by the trust agreement governing the plan.[25]

Finally, Section 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), requires trustees to comply with the terms of the plan's governing documents as long as those documents are consistent with ERISA. Therefore, if the trust agreement does not permit the trustees to extend coverage to individuals who are not covered by a collective bargaining agreement or participation agreement, the trustees breach this fiduciary duty if they provide benefits to such persons.

As a result of the Third Circuit's ruling in *United Wire*, fund trustees have been compelled to act in a manner inconsistent with ERISA's mandates by diverting millions of dollars to pay for the benefits of nonparticipants, as a result of the 19.1 percent surcharge specifically earmarked as a contribution toward uncompensated care. Although the Third Circuit stated that it was "not troubled" by this aspect of the cost-shifting structure of New Jersey's DRG statute, the NCCMP submits that the court of appeals failed to appreciate the requirements of ERISA and the LMRA, mischaracterized the surcharges as the mere cost of doing business in New Jersey, and ruled in a manner that is totally inconsistent with this Court's decision in *Local 144 Nursing Home Pension Fund, et al. v. Demisay*, 113 S.Ct. 2252 (1993).

[25] While the trust agreements of some multiemployer plans permit trustees to extend coverage to other classes of persons under participation agreements, for example, the employees of the union or the fund or the salaried employees of contributing employers, nothing in federal employee benefits law authorizes trustees to divert fund assets to finance the benefits of individuals who are not covered by any written agreement either with the union or the fund.

For the reasons stated above, the NCCMP submits that relevant federal law compels the preemption of New York's DRG surcharges with respect to self-funded multi-employer plans.

II. JUDICIAL EXEMPTIONS FROM ERISA'S PREEMPTION PROVISION INTRUDE IMPERMISSIBLY UPON AN AREA RESERVED EXCLUSIVELY TO CONGRESS.

In effect, Petitioners and their *amici* request that this Court, by judicial fiat, carve out an exception to preemption for state health care financing statutes on the assumption that Congress did not intend to prevent states from regulating health care costs under their traditional police powers even if such regulation results in the diversion of fund assets to pay for the benefits of nonparticipants. The NCCMP submits that Petitioners' assumption is incorrect. The NCCMP is therefore concerned that unless the Petitioners' reasoning is abandoned and the Second Circuit's opinion is affirmed, other courts of appeals[26] may be encouraged to carve out similar exemptions, not only for state health care financing laws but also for other laws promoting important state objectives,[27]

[26] In concluding that New Jersey's DRG surcharges were not preempted, the Third Circuit stated that it was "unwilling to attribute to Congress and § 514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs. In particular, we are unwilling to infer from ERISA's prohibition against applying fund assets for the benefit of others a Congressional intent to foreclose health care cost regulation of the kind here challenged." 995 F.2d at 1196.

[27] It may be recalled that prior to this Court's decision in *FMC Corp. v. Holliday, supra*, the Courts of Appeals for the Third and Sixth Circuits had carved out an exemption from preemption for state no-fault insurance statutes, opining that such statutes should be "saved" because they promoted important state interests without impermissibly intruding on "core" ERISA concerns. *FMC Corp. v. Holliday*, 885 F.2d 79 (3d Cir. 1989); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987). The NCCMP filed an *amicus* brief in *Holliday* because it feared

in derogation of Congress's determination that employee benefit plans should be regulated exclusively by federal law.

The plain language of ERISA Section 514, 29 U.S.C. § 1144, does not support broad-based judicial exemptions from preemption. First, § 514(a) clearly states that ERISA supersedes any and all state laws relating to employee benefit plans (with limited exemptions not relevant here). Nowhere in § 514 is there a legislative exemption for generally applicable state laws that also relate to employee benefit plans, no less for generally applicable state laws regulating health care. Rather, § 514(b)(2)(A) "saves" from preemption only those state laws that regulate insurance, banking, and securities (except as applied to self-insured plans which—under § 514(b)(2)(B)—are deemed not to be engaged in the business of insurance, banking, or securities for purposes of those laws), while § 514(b)(4) exempts generally applicable *criminal* laws from the reach of § 514(a).

Where Congress wished to create an exemption for state health care financing laws, it did so expressly in the statute. Thus, § 514(b)(5)(A) contains an express exemption for the Hawaii Prepaid Health Care Act while §§ 514(b)(5)(B) and (C) contain equally express limitations on the exemption.

that the "core ERISA concern" standard of preemption would erode the "deemer" clause and "save" a whole variety of state statutes and common law rules regulating insurance, banking and securities, since courts would be likely to differ on what they perceived as "core ERISA concerns." The NCCMP has even greater concerns with regard to the Third Circuit's approach in *United Wire* because, in contrast to *Holliday* which involved the scope of the "deemer" clause, the Third Circuit's interpretation of § 514(a) does not even leave open the possibility of distinguishing between self-funded and insured plans to secure the greater protection which this Court has afforded self-funded plans in *Metropolitan Life Ins. Co. v. Massachusetts, supra*, and in *Holliday*.

That state health care financing laws relating to employee benefit plans are clearly preempted by ERISA unless and until *Congress* decides to exempt them is clearly evidenced by a bill which Senator Durenberger introduced in September 1992.[28] That bill, entitled "State Health Care Financing Equity Act of 1992,"[29] was intended to waive certain preemption requirements of ERISA by adding two paragraphs (9 and 10) to § 514(b) to exempt from the reach of § 514(a) any qualified state health financing program that imposes a tax, premium, or surcharge on health plans doing business in the state (including self-funded plans) or requires such plans to participate in a risk pool for the medically uninsurable.[30]

The proposed bill expressly provided that states would not be prohibited from setting hospital rates prospectively under a DRG methodology which could include charges for uncompensated care as well as adjustments necessitated by Sections XVIII and XIX of the Social Security Act. However, states would have to apply for an ERISA waiver, and federal review and oversight was intended to be both comprehensive and pervasive, *inter alia*, to assure that the state law would be capable of fulfilling its goals and would also be nondiscriminatory.

In addition, four states (Hawaii, New York, Maryland, and Minnesota) applied for individual waivers from

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[28] S. 3223, 102nd Cong., 2nd Sess. (1992), 138 Cong. Rec. S13267-02.

[29] The bill was divided into two major sections, captioned "Waiver of ERISA Preemption for State Universal Health Plans" and "State Provider Taxes and Prospective Payment Systems."

[30] At the time the bill was submitted, 26 states had established risk pools to insure the medically uninsurable by assessing taxes and premiums on insurers, and other states were developing similar programs to provide broad-based access to health care to be financed by similar taxes or premiums. In addition, 22 states imposed taxes on hospitals, doctors, and other providers to finance uncompensated health care.

ERISA preemption—as part of the proposed Omnibus Budget Reconciliation Act of 1993—to allow them to regulate hospital rates and to permit them to recover the cost of providing indigent care by imposing surcharges and by increasing costs for health plan participants (including participants in self-funded plans).

Although the above proposals have not yet become law, it is clear that if exemptions from ERISA preemption are to be made for state health care financing statutes, pending national health care reform, the exemptions must be made by Congress and not by the courts, which are neither equipped nor authorized to solicit, process, or debate the type of broad-based information that must necessarily be considered and balanced in the course of amending a complex federal statute of great national scope, such as ERISA.

Pending federal legislation, however, the NCCMP requests this Court to reject Petitioners' "cost of doing business" standard, to adopt a preemption standard that will require courts to invalidate state laws imposing selective and differential burdens on ERISA plans, such as New York's DRG surcharges, and to clarify that economic considerations may justify preemption even if a state law is facially neutral.

CONCLUSION

For the reasons stated above, the NCCMP respectfully requests this Court to affirm the decision below and to rule that New York's DRG surcharges are preempted, at least with respect to self-funded ERISA plans.

Respectfully submitted,

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Dated: December 13, 1994

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